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February 21, 2023

WIC Administration, Benefits, and Certification Branch

Policy Division

Food and Nutrition Service

U.S. Department of Agriculture

P.O. Box 2885

Fairfax, Virginia 22031-0885

Re: RIN 0584-AE82 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): Revisions in the WIC Food Packages

Dear Ms Post:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents, and young adults, we appreciate this opportunity to provide comments on the U.S. Department of Agriculture's (USDA) proposed revisions to the food packages for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

WIC is one of the most effective federal nutrition programs supporting families from the prenatal to school-aged period. WIC provides nutritious foods, nutrition education, breastfeeding support, and referrals to health care and social services for millions of low-income women, their infants, and young children who are determined to be nutritionally at-risk. In providing this nutritional support and linkages with health care, WIC builds good health and promotes resilience in families at risk, helping to mitigate the effects of toxic stress. WIC helps give children a healthy start at life, and children who receive WIC have improved birth outcomes, increased rates of immunization, better access to health care through a medical home, and participation may help reduce childhood obesity.

One of the hallmarks of any successful nutrition and health care intervention is its evidence and science base. WIC participants may not purchase just any food. The WIC food packages are based on what nutrition science experts recommend is needed to meet the nutritional needs of pregnant and breastfeeding women and young children. As such, we are supportive of USDA's efforts to move forward with a science-based process to update the WIC food packages drawing upon the best available science, including expert recommendations from the National Academies of Sciences, Engineering and Medicine [review](#) of the WIC food packages, the [Dietary Guidelines for Americans](#) (DGA) 2020-2025, and the Food and Drug Administration's (FDA) and Environmental Protection Agency's (EPA) 2021 joint [Advice about Eating Fish](#).

Recent research found that science-based changes made to the WIC food packages in 2009 may have helped to reverse the rapid increase in obesity prevalence among WIC participants observed before the food package change.ⁱ Participants purchased and consumed less fruit juice, refined grains, grain-based desserts, and sugar-sweetened beverages while increasing purchases and consumption of fruits, vegetables, and whole grains. This dietary pattern has been associated with less weight gain in both children and adults. Another recent study provides some of the first evidence that children of mothers who received the revised WIC food

package during pregnancy had improved developmental outcomes in the first two years of life.ⁱⁱ These findings underscore the importance of ensuring that the nutrition content of federal programs is determined by nutrition scientists and medical professionals. We also urge USDA to consider feedback on the proposed food packages from families who participate in WIC when drafting the final rule. It is our hope that the revision of the WIC food packages that is in progress will lead to improved dietary patterns and outcomes for WIC families.

Our comments on specific proposals in the rule are detailed below.

Fruits and Vegetables

AAP is pleased that USDA is proposing to significantly expand the Cash Value Benefit (CVB) for fruit and vegetable purchases and is hopeful that this expanded benefit will encourage WIC families to increase their fruit and vegetable consumption. Higher fruit and vegetable issuance is critical for improving health outcomes and closing intake disparities. Though WIC is a supplemental program, the value of the fruit and vegetable benefit is often not enough to ensure that families have regular access to nutritious foods, which are often higher-cost and out of reach for many low-income families. The increased CVB for fruit and vegetable purchases that Congress has provided to WIC families during the pandemic has been well received by program participants and has resulted in rapid and measurable increases in fruit and vegetable consumption (averaging at ¼ cup per day for WIC-enrolled children).ⁱⁱⁱ We thank USDA for proposing to continue offering higher CVB amounts to all WIC participants.

We urge USDA to ensure that there is no interruption in increased benefit levels while the temporary increase provided by Congress is replaced by the permanent increase in the CVB proposed in this rule. Given that studies have found that only approximately 30% of preschoolers meet the 5-a-day recommendations for vegetables and fruits,^{iv} it is important for USDA to continue to incentivize fruit and vegetable consumption with an increased benefit. For our patients, an increase in benefits will help them afford the healthy foods they need to thrive.

While we are supportive of allowing CVB redemption for additional forms of fruits and vegetables, including frozen and canned, we urge USDA to take steps to encourage families to choose fresh and frozen fruits and vegetables without additives over canned options that may contain added sugars or sodium. While canned fruits and vegetables may be less nutritious than fresh or frozen, for some families canned may be the only feasible option. WIC clinics should provide education around the benefits of selecting fresh or frozen options compared to canned. USDA may consider an added sugar or sodium limit on canned fruits and vegetables if there are sufficient options available on the market that would meet such a limit.

AAP supports the intent of the provision requiring WIC retailers to stock three varieties of vegetables but urges USDA to monitor its effects upon implementation in order to ensure that the requirement is not so onerous that retailers leave the program. Pediatricians are also supportive of the proposal to allow CVB redemption for fresh, cut herbs like cilantro and basil as these are often used in the preparation of cultural meals.

Juice

AAP is strongly supportive of USDA's proposal to reduce juice in the child food package. Children should be encouraged to eat whole fruits to meet their recommended daily fruit intake.^v Intake of 100% fruit juice should be monitored and in moderation as overconsumption of juice can contribute to pediatric obesity, dental decay, and unhealthy eating habits.^{vi} Limiting juice consumption leaves room for the consumption of more nutritious foods like whole fruits and vegetables. Parents should be educated regarding the benefit of fiber intake from whole fruit relative to juice, and conversely, the potential concerns about dental caries and excessive energy intake from fruit juice relative to whole fruit.^{vii}

The reduced quantities of juice proposed by USDA would provide approximately 50% of AAP's recommended limit for juice consumption, consistent with WIC's supplemental nature.^{viii} However, given that AAP's juice guidance is a daily limit and not a recommended amount for consumption, we fully support the proposed option to substitute the juice benefit for an additional \$3 in CVB. Because evidence shows that "opt-in" programs often result in individuals making healthier choices when the healthier choice is the default, we urge USDA to go a step further and make the additional \$3 CVB the default option and require families to affirmatively choose to substitute that amount for a juice benefit.

By decreasing overall juice issuance and boosting CVB for whole fruit purchases, WIC can work to reverse intake disparities that disproportionately affect low-income families and, in particular, Black children.^{ix} WIC participation is associated with earlier introduction of juice^x and higher rates of consumption when compared to non-participants.^{xi} By eliminating default juice issuance, WIC can better align participant perceptions and nutrition education messages with medical advice.

Milk and Milk Substitutions

Dairy products play an important role in the diet of children. Milk constitutes the leading source of daily energy, macronutrients, and many vitamins and minerals, including vitamins A and D, calcium, and zinc for toddlers.^{xii} While the rule proposes to reduce the maximum monthly allowances for milk, these reductions are consistent with the WIC program's supplemental nature.

Dairy-free alternatives to milk can be helpful for children with milk allergies or other dietary restrictions. While some of these products are fortified with calcium and protein, many of these products lack the essential nutrients that dairy products contain to promote the healthy development of children, notably protein, calcium, and vitamin D.^{xiii} AAP would be supportive of the addition of dairy-free alternatives to the WIC food package so long as their protein, vitamin D, and calcium amounts are similar to milk and that they do not contain significant added sugars. We support the addition of soy-based yogurt and soy-based cheeses meeting the proposed nutrient specifications as substitution options for milk.

AAP strongly supports the requirement that all milk in WIC food packages be unflavored. The DGA recommend that added sugars contribute less than 10% of total calories consumed, yet U.S. children and adolescents report consuming 17% of their calories from added sugars, nearly half of which are from sugary drinks, including flavored milks. Excess consumption of added sugars, especially from sugary drinks, contributes to the high prevalence of childhood and adolescent obesity, especially among children and adolescents who are socioeconomically vulnerable.^{xiv} It also increases the risk for dental decay, cardiovascular disease hypertension, dyslipidemia, insulin resistance, type 2 diabetes mellitus, fatty liver disease, and all-cause mortality. Decreasing sugary drink consumption is of particular importance because sugary drinks are the leading source of added sugars in the U.S. diet, provide little to no nutritional value, are high in energy density, and do little to increase feelings of satiety.

Similarly, AAP supports the proposed limit on the amount of total sugars for yogurt and soy-based beverages. While the rule follows the NASEM report in proposing a limit on total sugars, we recommend USDA instead adopt a nutritionally comparable added sugars limit, given the DGA guidance around limiting added sugars and that other federal nutrition programs are moving towards the use of standards based on added sugars instead of total sugars.

Pediatricians are supportive of the proposal to allow reduced fat yogurts to be issued to children 12 through 23 months without restrictions as well as the proposal to require state agencies to authorize lactose-free milk.

Infant Foods

Iron plays a role in multiple essential physiological functions, including oxygen transport, gene regulation, DNA synthesis, DNA repair, and brain function. Depletion of and inability to use iron disrupts these pathways and causes multiple morbidities.^{xv} Most healthy infants born at term have sufficient iron stores to last until four to six months of age.^{xvi} The common practice of introducing infant cereals as a first complementary food is based on the recognized need for iron; essentially all commercial infant cereals in the United States are iron fortified.^{xvii} USDA proposes reducing the amounts of infant cereal available to WIC participants. If finalized as proposed, iron levels, particularly in breastfed infants, should be monitored to make sure optimal iron status is maintained.

USDA also proposes reducing the amounts of jarred infant meat products available to fully breastfed infants, which AAP does not support. As USDA notes in the rule, infant meat products are an important iron source for fully breastfed infants, but WIC redemption rates are currently low. Meats containing heme iron should be encouraged, given its better bioavailability and improved enteral absorption (20-35%) than iron in fruits and vegetables.^{xviii}

Breastfeeding and Infant Formula

Partially Breastfed Infants

Breastfeeding and human milk are the normative standards for infant feeding and nutrition. The short- and long-term medical and neurodevelopmental advantages of breastfeeding make breastfeeding, or the provision of human milk, a public health imperative. In addition to its nutritional benefits, breastfeeding protects against respiratory and gastrointestinal tract infections, ear infections, and may be linked to lower obesity rates in adolescence and adulthood.^{xix} AAP recommends exclusive breastfeeding for approximately six months after birth.^{xx} Furthermore, the AAP supports continued breastfeeding, along with appropriate complementary foods introduced at about six months, as long as mutually desired by mother and child for two years or beyond. These recommendations are consistent with those of the World Health Organization (WHO).^{xxi}

Breastfeeding exclusively for about 6 months is an evidence-based recommendation; however, we recognize that structural barriers to breastfeeding may exist that make it difficult for families to exclusively breastfeed. In an effort to encourage WIC participants in the early postpartum period to try to breastfeed, the proposed rule would increase the maximum monthly infant formula amounts in the first month for partially (mostly) breastfed infants from 104 fluid ounces to up to 364 fluid ounces. The rule would also create a separate, enhanced food package for partially breastfeeding women, intended to promote breastfeeding among participants who are not exclusively breastfeeding their infants and align with the higher calorie needs of breastfeeding individuals. While some breastfeeding is better than no breastfeeding, we support societal changes that permit continued exclusive and direct breastfeeding, such as guaranteed paid maternity leave, flexible work schedules, including working from home, and on-site child care.^{xxii}

WIC is an essential program to assist in the promotion of breastfeeding by directly engaging with mothers and families. It is imperative that the amount of formula provided in the first month for partially (mostly) breastfed infants be tailored based upon an individual nutrition and breastfeeding assessment. In an individual counseling situation, families can discuss their desires, constraints, and cultural variations. Counselors can review the importance of exclusive breastfeeding and ensure families are fully informed about their decisions (and discuss how combination feeding can lower milk supply), while at the same time engaging in nonjudgmental conversations about the family's personal goals for breastfeeding.^{xxiii} Counselors can also follow-up with families to see if the breastfeeding situation is improving and ensure that families have access to a breast pump or a lactation professional. Exclusive or any breastfeeding is not always possible, despite the

best of intentions, and these mothers and families need special support to overcome the disappointment that may accompany breastfeeding difficulties.^{xxiv}

WIC has played an important role in promoting breastfeeding but more progress can be made. In order to support WIC participants to move closer to meeting AAP recommendations and national targets for breastfeeding, we urge USDA to find ways to promote breastfeeding in the WIC program including through expansion of the successful breastfeeding peer counseling program within WIC. The breastfeeding peer counselors program both creates jobs and supports women to meet their breastfeeding goals. Pediatricians often speak to how effective and helpful this program is to both families and pediatricians.

Iron Standard for Infant Formula

The Department requests public comment on the current iron standard of 1.5 milligrams of iron per 100 kcal at standard dilution, with specific interest in the effect of reducing the standard while providing sufficient supplementation to prevent iron deficiency in infants. For the last 20 years, standard infant formulas in the United States have contained 12mg of iron/L, higher than in other countries. This amount was calculated to supply all of the exogenous iron requirements of a normal formula-fed full-term infant for the first year of life. Because a normal infant has iron sources other than formula (especially cereal and meats), the 12mg/L iron formula appears to supply more iron than is necessary. Concerns have been expressed that this amount of iron may have associated risks; however, the AAP has concluded that infant formula containing 12 mg of elemental iron/L is safe for its intended use.^{xxv} Although some concerns are expressed about linear growth in iron-replete infants receiving additional iron, no published studies have convincingly documented decreased linear growth in iron-replete infants receiving formulas containing high amounts of iron.^{xxvi} Evidence is also insufficient to associate formulas containing 12mg of iron/L with gastrointestinal tract symptoms.^{xxvii}

Whole Grains

AAP is supportive of USDA's decision to take up the NASEM recommendation to require that all breakfast cereals meet the criteria for whole grain. NASEM identified that 100% of adults and 93% of children do not meet DGA-recommended intake for whole grains,^{xxviii} with children instead exceeding recommended refined grain intake.^{xxix} Black and Hispanic families face the greatest intake disparities, with the average Hispanic toddler consuming only 26% of recommended whole grain intake.^{xxx} Requiring whole grain breakfast cereals will help to address this gap in recommended consumption. AAP also supports an added sugars limit for breakfast cereal.

Pediatricians are also supportive of the proposal to make additional whole grain options, including quinoa, barley, and teff, available to WIC participants. The increased availability of whole grains that align with cultural eating patterns will be especially impactful for immigrant families who participate in WIC. As the rule is implemented, we urge USDA to ensure that there is flexibility for cultural choices as well as participant education around what options are available.

Canned Fish

AAP strongly supports the rule's proposal to add canned fish to the food packages for children, pregnant, postpartum, and partially breastfeeding participants but urges USDA to go further in providing fish to children beginning at age one. American children eat relatively little fish and shellfish in comparison with other sources of animal protein, despite the health benefits that eating fish and shellfish may confer.^{xxxi} Fish and shellfish are, in general, good sources of low-fat protein rich in several essential vitamins and minerals as well as, in certain instances, the essential nutrients omega-3 long-chain polyunsaturated fatty acids. Studies suggest seafood consumption may improve infant neurodevelopment and decrease cardiovascular disease risk.

Research corroborates the potential for early fish consumption having durable protective effects.^{xxxii} A growing body of research shows that introducing fish early in a child's diet may even help prevent allergic disease such as asthma and eczema. However, waiting until age two to introduce seafood into the diet may be too late to reduce allergies and to increase palatability in children. We urge USDA to make canned fish available to one-year olds so that they are able to take full advantage of the benefits of seafood consumption.

While fish is a nutritious choice for families, it may also be a source of toxicants. However, exposure to mercury in fish can be minimized or avoided by following the FDA and EPA guidance based on estimated methylmercury exposure. We appreciate that the proposed rule includes three canned fish options that are labeled as "Best Choices" in the FDA-EPA guidance, but we urge USDA to go further to include additional "Best Choices" as options for WIC participants. Clams, for example, are very high in iron, and would make a good addition to children's diets. Canned or pouched light tuna is also popular and should be available. We urge USDA to be as inclusive as possible with regards to canned fish and to allow WIC participants to redeem benefits for any of the "Best Choices" options, including clams and light tuna.

Legumes and Eggs

AAP supports the addition of canned beans to the WIC food package as canned beans are often easier than dried beans for families to prepare. Pediatricians support the option to substitute peanut butter, tofu, and legumes as substitutes for eggs, particularly for those with egg allergies. We suggest allowing other nut and seed butters in addition to peanut butter given the prevalence of peanut allergies. However, we urge caution as many of these nut and seed butter products contain high amounts of added sugar.

Maximum Monthly Allowances

AAP is supportive of the proposals in the rule that allow flexibility in product package sizes as they will expand options for WIC families and reduce barriers in the shopping experience.

Food Allergies

Food allergy affects 4% to 8% of children in the United States and appears to be increasing in prevalence.^{xxxiii} Because food allergies can be severe and potentially fatal, careful diagnostic assessments and appropriate education regarding allergen avoidance and treatment of reactions are warranted.^{xxxiv} Given the high prevalence of food allergies and the undesired consequences that can be associated with intakes of allergens, we urge WIC to allow for flexibility and modifications in WIC food package redemptions for individuals with allergies. For children on limited diets, nutrition counseling and growth monitoring is recommended.^{xxxv}

Reducing Barriers to WIC

Despite the demonstrated positive impact of WIC, only half of eligible individuals are typically certified to receive WIC services. Pediatricians routinely report that families opt not to remain in the program after their child's first birthday. Many more have spent considerable time counseling immigrant families about the importance of WIC and clarifying that the program is not subject to the now defunct 2019 public charge rule only to be met with skepticism or reluctant interest. Families without reliable transportation often find it difficult to get to the WIC clinic to remain on the program. Others faced a lapse in benefits when their children turned five but had not yet started kindergarten where they could participate in the school meals program.

While reasons for this vary from family to family, barriers that families face to enroll and remain enrolled in the program should be eliminated. One such barrier that families cite is the need to travel to a WIC clinic to enroll in the program or receive nutrition education. The waivers provided by USDA to allow remote enrollment, services, and benefits issuance during the COVID-19 public health emergency have been crucial to helping families in need. We are grateful for USDA's recent steps to allow states to continue to remotely certify families for WIC and provide benefits remotely while also requiring states to provide an in-person option for

participants. We urge states to take up this option in order to lessen the existing barriers to participation in WIC.

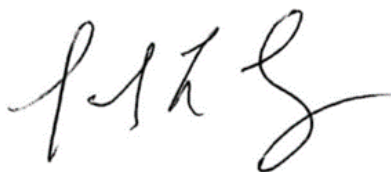
WIC clinics can also reach more eligible families if they are in locations where potential participants already go for other services or that are part of their normal routine.^{xxxvi} Pediatricians report finding this to be an incredibly important strategy in reducing barriers for families. This can also be accomplished by permanently co-locating a WIC clinic in a community health center or a hospital.^{xxxvii}

AAP strongly supports giving states the option to reduce administrative barriers for families of infants and helping them stay connected to WIC by extending the recertification period from 12 months to 24 months. We believe this would have a meaningful impact on ensuring children continue to access the benefits of WIC after their first birthday. Additionally, we support extending WIC eligibility to age six in order to cover children who are neither age-eligible for school - and therefore school meals - nor eligible for WIC. Eligibility for postpartum women should be extended to two years in order to ensure that women have access to healthy foods between potential subsequent pregnancies, thus reducing the risk of negative birth outcomes.

Lastly, it is important to align WIC eligibility with other federal programs like Medicaid and SNAP in order to combat declining enrollment and reduce certification and eligibility requirements. Adjunctive eligibility between WIC and Medicaid streamlines the WIC application process, reduces administrative burdens, increases coordination between these complementary programs, and should be maintained. As the Medicaid continuous coverage requirement under the COVID-19 public health emergency comes to an end, we urge USDA to pay special attention to how disenrollments from Medicaid may impact families adjunctively eligible for WIC. Families who remain eligible for WIC should not experience a lapse in benefits. Education and outreach to families by USDA, state WIC agencies and other stakeholders is critically important as the continuous coverage requirement and public health emergency come to an end.

Thank you for the opportunity to provide comments on this proposed rule. We are grateful for the work that USDA is doing to ensure that WIC families are able to access healthy foods and look forward to the finalization of this rule. If you have additional questions or if we can be of assistance, please contact Madeline Curtis in AAP's Washington Office at mcurtis@aap.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Chung', written in a cursive style.

Sandy L. Chung, MD, FAAP
President

SLC/mrc

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- ^{xviii} American Academy of Pediatrics, Committee on Nutrition, *Pediatric Nutrition*, November 2019, 570.
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